

4425

CERTIFICATE OF DEATH

04428

Reg. Dist. No. 252

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt 15 Centerville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>WALTON</u> Last <u>BENTON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 17-1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm tenant</u>			
13. FATHER'S NAME <u>Nathan E. Benton</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Walls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>222-26-1570</u>			
17. INFORMANT <u>Dudley Benton</u> Address <u>Centerville Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcohol - excess</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 1 - 1957</u> to <u>4-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>57</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED <u>4-20-57</u>			
ACTUAL SIGNATURE <u>H. J. McArthur</u> M.D.							
PHYSICIAN'S NAME (Type) <u>H. J. McArthur</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 20. 57</u>		<u>Chestfield</u>		<u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Baiton</u> ADDRESS <u>Baiton Bros Centerville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elice Ametroug</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF CHURCH [Faint text]</p>		<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	
<p>19. SIGNATURE OF OTHER [Faint text]</p>		<p>20. SIGNATURE OF OTHER [Faint text]</p>	
<p>21. SIGNATURE OF OTHER [Faint text]</p>		<p>22. SIGNATURE OF OTHER [Faint text]</p>	
<p>23. SIGNATURE OF OTHER [Faint text]</p>		<p>24. SIGNATURE OF OTHER [Faint text]</p>	
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<p>65. SIGNATURE OF OTHER [Faint text]</p>		<p>66. SIGNATURE OF OTHER [Faint text]</p>	
<p>67. SIGNATURE OF OTHER [Faint text]</p>		<p>68. SIGNATURE OF OTHER [Faint text]</p>	
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<p>71. SIGNATURE OF OTHER [Faint text]</p>		<p>72. SIGNATURE OF OTHER [Faint text]</p>	
<p>73. SIGNATURE OF OTHER [Faint text]</p>		<p>74. SIGNATURE OF OTHER [Faint text]</p>	
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<p>77. SIGNATURE OF OTHER [Faint text]</p>		<p>78. SIGNATURE OF OTHER [Faint text]</p>	
<p>79. SIGNATURE OF OTHER [Faint text]</p>		<p>80. SIGNATURE OF OTHER [Faint text]</p>	
<p>81. SIGNATURE OF OTHER [Faint text]</p>		<p>82. SIGNATURE OF OTHER [Faint text]</p>	
<p>83. SIGNATURE OF OTHER [Faint text]</p>		<p>84. SIGNATURE OF OTHER [Faint text]</p>	
<p>85. SIGNATURE OF OTHER [Faint text]</p>		<p>86. SIGNATURE OF OTHER [Faint text]</p>	
<p>87. SIGNATURE OF OTHER [Faint text]</p>		<p>88. SIGNATURE OF OTHER [Faint text]</p>	
<p>89. SIGNATURE OF OTHER [Faint text]</p>		<p>90. SIGNATURE OF OTHER [Faint text]</p>	
<p>91. SIGNATURE OF OTHER [Faint text]</p>		<p>92. SIGNATURE OF OTHER [Faint text]</p>	
<p>93. SIGNATURE OF OTHER [Faint text]</p>		<p>94. SIGNATURE OF OTHER [Faint text]</p>	
<p>95. SIGNATURE OF OTHER [Faint text]</p>		<p>96. SIGNATURE OF OTHER [Faint text]</p>	
<p>97. SIGNATURE OF OTHER [Faint text]</p>		<p>98. SIGNATURE OF OTHER [Faint text]</p>	
<p>99. SIGNATURE OF OTHER [Faint text]</p>		<p>100. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. 5

APR 24 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chester</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Devica</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 - 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>7 weeks</u>
11. BIRTHPLACE (State or foreign country) <u>Chester Md - RFD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Clark</u>		14. MOTHER'S MAIDEN NAME <u>Ada Ebborn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infantile Convulsions</u> <u>780.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 9</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR <u>4/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Ely abeth Hopton</u>	

100-244 XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME LAST, FIRST, MIDDLE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF DEATH MONTH DAY YEAR	
PLACE OF DEATH STREET, CITY, STATE, ZIP		DECEASED'S RESIDENCE STREET, CITY, STATE, ZIP	
OCCUPATION TRADE, VOCATION, OR BUSINESS		CAUSE OF DEATH (List in order of occurrence)	
MANNER OF DEATH (Check one) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL HISTORY (Check one) <input type="checkbox"/> None <input type="checkbox"/> Chronic <input type="checkbox"/> Acute	
SIGNATURE OF EXAMINER (Print name and title)		SIGNATURE OF DECEASED'S NEAREST RELATIVE (Print name and relationship)	
DATE OF EXAMINATION MONTH DAY YEAR		TIME OF EXAMINATION HOUR MINUTE	

RECEIVED

BUREAU V. 3

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4427

CERTIFICATE OF DEATH

Reg. Dist. No.

04430

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First <u>HOWARD</u> Middle <u>COPPAGE</u> Last		4. DATE OF DEATH <u>APRIL</u> Month <u>14</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN COPPAGE</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WM. GOULD - CHESTERTOWN MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 years</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>54</u> , to <u>3-14</u> , 19 <u>57</u> , that I lost the deceased alive on <u>3-13</u> , 19 <u>57</u> , and that death occurred at <u>1:15</u> p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		DATE SIGNED <u>4-16-57</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick,</u>		<u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>April 17</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>	22d. LOCATION (City, town, or county) (State) <u>Sudlersville Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24. REC'D BY REGISTRAR <u>4-16</u>	
ADDRESS <u>Church Hill Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF MENTAL HEALTH PROFESSIONAL		16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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BUREAU V. 5

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04431

4428

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>g. a.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charleston R.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO rye Lewis cor.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Malvin</u> Last <u>Crew</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>m.</u>		6. COLOR OR RACE <u>w.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 5-1889</u> 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Cannon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>212-12-2617A</u>		17. INFORMANT Address <u>Floyd Crew Charleston R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of prostate + bladder</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 2</u> , 1957, to <u>April 6</u> , 1957, that I last saw the deceased alive on <u>April</u> , 1957, and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				DATE SIGNED <u>4/9-57</u>			
PHYSICIAN'S NAME (Type) <u>W. Henry Fisher</u>				ADDRESS (Street, city or town, state) <u>Centreville Md</u> <u>Centreville, Maryland</u>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)		22b. DATE THEREOF <u>Apr. 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crompton</u>		22d. LOCATION (City, town, or county) <u>Crompton</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>4-9</u> DATE <u>4-9</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>			

BUREAU V. S.

APR 15 1957

RECEIVED

4429

CERTIFICATE OF DEATH

Reg. Dist. No.

252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ga.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. LENGTH OF STAY IN 1b <u>38 yrs -</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>1 Kidwell Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC EDWARD DOLBY</u>				4. DATE OF DEATH Month Day Year <u>April 1 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July-16-1865</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Dealer</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Heram Dolby</u>			
14. MOTHER'S MAIDEN NAME <u>Rachael Le Gates</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT Address <u>Nelson Hunter Centerville Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>156.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan 1953</u> to <u>Apr 1 1957</u> , that I last saw the deceased alive on <u>Nov 20 1957</u> , and that death occurred at <u>11 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. M. Thiesse</u> M.D.				ADDRESS (Street, city or town, state) <u>Centerville MD</u>			
DATE SIGNED <u>4-2-57</u>				PHYSICIAN'S NAME (Type) <u>H. F. M. Thiesse</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. B. Beck</u> ADDRESS <u>Centerville Maryland</u>				24a. REC'D BY REGISTRAR <u>4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elie Armstrong</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU T. 3

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG214 4-18-57 et

4430

CERTIFICATE OF DEATH

04433

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u> <u>46X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>1019 Chestnut St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH J DUNN</u>				4. DATE OF DEATH <u>March 30 1957</u>			
5. SEX <u>+</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1876</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Talbot Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. S. Corington</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Sinclair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ? (known) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>W. S. Corington</u> Address <u>Centerville Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/31</u> , 19 <u>57</u> , to <u>4/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>57</u> , and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Foster</u> M.D.				ADDRESS (Street, city or town, state) <u>Centerville Md</u>		DATE SIGNED <u>4/1-57</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Memorial</u>		22d. LOCATION (City, town, or county) <u>Wilmington Delaware</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Barton Barton Bros Centerville Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE 4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elaine Armstrong</u>	

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4431

CERTIFICATE OF DEATH

04434

Reg. Dist. No.

253

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	c. LENGTH OF STAY IN 1b <u>84yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Char</u> Middle <u>lotte</u> Last <u>Elizabeth Hazelton</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George H. Richardson</u>	
14. MOTHER'S MAIDEN NAME <u>Charlotte Dunn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Eliza Derry</u> Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO <u>12hrs.</u> (c) <u>Arteriosclerotic CV Disease</u> <u>? yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 9</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>4/12/57</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester</u>	22d. LOCATION (City, town, or county) (State) <u>Chester Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Bickel</u> ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Ely. Hoyt</u>

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is filled out with handwritten text, which is mostly illegible due to blurring and bleed-through. Some legible text includes "Bureau V. 3" and "APR 22 1957".

RECEIVED

APR 22 1957

BUREAU V. 3

4432

CERTIFICATE OF DEATH

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>all of life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>Heath</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 27, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Grasonville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Heath</u>		14. MOTHER'S MAIDEN NAME <u>Mary Heath</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-2266</u>	
17. INFORMANT <u>Sullivan Heath</u> Address <u>Grasonville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis general + cerebral</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>March 20, 1957</u> <u>10 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage</u> <u>Oct. 1955.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1946</u> , to <u>April 8, 1957</u> , that I last saw the deceased alive on <u>April 7, 1957</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>April 8, 1957</u>	
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER</u>		<u>STEVENSVILLE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Robinson A.M.E. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Grasonville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Williams</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 9-'57</u> 24b. REGISTRAR'S SIGNATURE <u>Allen M. Dedudge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 11

APR 15 1957

RECEIVED

4433

CERTIFICATE OF DEATH

Reg. Dist. No.

254

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown x1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Hyson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16, 1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alce Hyson</u>				14. MOTHER'S MAIDEN NAME <u>Alce Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Louise Coleman</u>		Address <u>Queenstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>? yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>56</u> , to <u>April 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>57</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. DATE SIGNED <u>4/5/57</u> ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <u>Irvin G. Hext MD</u> M.D.				DATE SIGNED <u>4/5/57</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hext MD</u>				Address <u>Queenstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Oakhill Easton, Inc.</u>				24. REGISTERED BY REGISTRAR <u>APR 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Delores Aldridge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

APR 22 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4434

CERTIFICATE OF DEATH

04437

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRICE	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRICE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT F. LEAGER		4. DATE OF DEATH APRIL 3 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 16 - 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT F. LEAGER		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME MELLIE HARGADINE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchio Pneumonia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis Cerebral Sclerosis DUE TO 8 years (c) Generalized Arteriosclerosis DUE TO 15 years			INTERVAL BETWEEN ONSET AND DEATH 6 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Haemorrhage - 1951			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10 , 1957, to April 3 , 1957, that I last saw the deceased alive on April 1 , 1957, and that death occurred at 10:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. R. LAYTON		ADDRESS (Street, city or town, state) Centreville Md. DATE SIGNED Apr 16, 1958	
PHYSICIAN'S NAME (Type) C. R. LAYTON		Centreville Ind. 4-16	
22a. BURIAL, CREMATION, REMOVAL (Specify) ARRIA 6	22b. DATE THEREOF ARRIA 6	22c. NAME OF CEMETERY OR CREMATORY Sudlersville	22d. LOCATION (City, town, or county) (State) Sudlersville Ind.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar H. Lane ADDRESS Church Hill Md.		24a. REC'D BY REGISTRAR DATE 4-16	24b. REGISTRAR'S SIGNATURE Edgar H. Lane

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04438

4435

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>PRITCHETT</u> Last <u>PRITCHETT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 - 1924</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Centreville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Rayfield Rogier</u>		14. MOTHER'S MAIDEN NAME <u>Susie Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-14-3924</u>	
17. INFORMANT <u>Susie D Rogier</u>		Address <u>Centreville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>199.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Barrel-shaped metastasizing</u> DUE TO (c) <u>Carcinoma Rt Kidney + Cervix</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 week</u> <u>9 mo</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 16, 1956</u> , to <u>April 7, 1957</u> , that I last saw the deceased alive on <u>April 5, 1957</u> , and that death occurred at <u>12:34 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		ADDRESS (Street, city or town, state) <u>Centreville Md</u> DATE SIGNED <u>4-10-57</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Layton MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Earl Burt</u> ADDRESS <u>Centreville Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Elaine Armstrong</u>

CERTIFICATE OF DEATH

4132

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5'10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM	
APR 4 1968		MEMPHIS		SHOOTING		SUICIDE		HEART DISEASE		BLOOD POISONING		NO		NO	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
BUREAU V. 1
 APR 22 1968

4436

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POND TOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POND TOWN, RURAL CHESTERTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 28, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>EDWARD TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>OCTAVIA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ARTHUR TAYLOR, RURAL, CHESTERTOWN, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation of the heart -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degeneration of the heart muscle -</u> DUE TO (c) <u>Coronary thrombosis -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 week -</u> <u>3 years -</u> <u>3 years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 18, 1957</u> , to <u>April 21, 1957</u> , that I last saw the deceased alive on <u>April 22, 1957</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edgar L. Lane</u> M.D.		ADDRESS (Street, city or town, state) <u>Wilmington, DE</u> DATE SIGNED <u>4-26-57</u>	
PHYSICIAN'S NAME (Type) <u>GEZA KORALEWSKI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>POND TOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR <u>Edgar L. Lane</u>	
ADDRESS <u>Wilmington, DE</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 30 1957

BUREAU V. 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
RACE: [illegible]
OCCUPATION: [illegible]
EDUCATION: [illegible]
MARRIAGE: [illegible]
RELIGION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF CORONER: [illegible]
SIGNATURE OF JUDGE: [illegible]
SIGNATURE OF CLERK: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04440

253

4437

1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSVILLE</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>DENNY</u> Middle <u>TOLSON</u> Last				4. DATE OF DEATH <u>APRIL</u> Month <u>24</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1869</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM OWNER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN HENRY TOLSON</u>			
14. MOTHER'S MAIDEN NAME <u>VICTORIA COCKEY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MARGARET TOLSON</u> Address <u>STEVENSVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute meningitis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis general + cerebral</u> 10 years DUE TO (c) <u>Diabetes mellitus</u> 15 years							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>55</u> , to <u>April 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>57</u> , and that death occurred at <u>12 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>April 24, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u>				STEVENSVILLE Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 26</u>		<u>Stevensville</u>		<u>Stevensville Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elgar H. Kane</u> ADDRESS <u>Stevensville Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>April 26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hyster</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

APR 30 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04441
 Reg. Dist. No. 254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Stevensville RFD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wm</u> First <u>Roseberry</u> Middle <u>Wright</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 22 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, often if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rent Island</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Island</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>J. Lee Nixon</u>				14. MOTHER'S MAIDEN NAME <u>Emma Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-30-2255</u>		17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>He was dead when he arrived</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. Henry Fisher</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL OR CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr. 30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baths Neck</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Queen Anne</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Serviss & Henry</u>				ADDRESS <u>1307 md ave</u> <u>Baths</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>4-28-57</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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APR 30 1957